South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

SUMMARY OF REQUIREMENTS FOR A LICENSE TO PRACTICE MEDICINE

To obtain a permanent license to practice medicine in this State, an applicant shall comply with the following requirements as outlined in Section 40-47-32 of the Medical Practice Act:

A. EDUCATION REQUIREMENTS

a. Graduated from a medical school located in the United States or Canada that is accredited by the Liaison Committee on Medical Education or other accrediting body approved by the board; or
b. Graduated from a school of osteopathic medicine located in the United States or Canada accredited by the Commission on Osteopathic College Accreditation or other accrediting body approved by the board; or
c. Graduated from a medical school located outside the United States or Canada must:
    1. possess a permanent Standard Certificate from the Education Commission on Foreign Medical Graduates (ECFMG).
    2. notwithstanding the provisions of this subsection, the board may waive the ECFMG or Fifth Pathway requirement if the applicant is to have a full-time academic faculty appointment at the rank of assistant professor or greater at a medical school in this State.

B. POSTGRADUATE TRAINING REQUIREMENTS

1. Graduates of approved medical or osteopathic schools located in the United States or Canada shall document the successful completion of a minimum of one year of postgraduate medical residency training approved by the board.
2. Graduates of medical schools located outside the United States or Canada shall document a minimum of three years of progressive postgraduate medical residency training in the United States approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons, except that if an applicant has been licensed in another state for five years or more, the applicant is only required to document one year of postgraduate residency training approved by the board; or
    a. document successful completion of a Fifth Pathway Program; and
    b. complete a minimum of three years progressive postgraduate medical residency training in the United States approved by the ACGME or AOA or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons or be board eligible or board certified by a specialty board recognized by the American Board of Medical Specialties (ABMS), the AOA, or another organization approved by the board;
    c. graduates who have completed at least two and one-half years of progressive postgraduate medical residency training in the program in which they are currently enrolled may be issued a license upon certification from the program of their good standing and expected satisfactory completion.
    d. graduates who have been licensed in another state for five years or more without significant disciplinary action need only document one year of postgraduate residency training approved by the board.
    e. foreign graduate may satisfy the three year postgraduate training requirement with at least one year of approved training in combination with certification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.
    f. notwithstanding the provisions of this subsection, the board may waive the ECFMG or Fifth Pathway requirement if the applicant is to have a full-time academic faculty appointment at the rank of assistant professor or greater at a medical school in this State.
3. The board may accept a full-time academic appointment at the rank of assistant professor or greater in a medical or osteopathic school in the United States as a substitute for and instead of postgraduate medical residency training. Each year of this academic appointment may be credited as one year of postgraduate medical residency training for purposes of the board's postgraduate training requirements.
4. For purposes of satisfying postgraduate medical residency training requirements, the board may accept postgraduate training in the United States approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association or postgraduate training in Canada approved by the Royal College of Physicians and Surgeons.

Revised 6/9/14

C. EXAMINATION REQUIREMENTS

An applicant shall document to the satisfaction of the board successful completion of:

(1) all parts of the National Board of Medical Examiners Examination in approved sequence;
(2) all parts of the National Board of Osteopathic Medical Examiners Examination in approved sequence;
(3) the Federation Licensing Exam (FLEX) based on standards established by the board;
(4) the United States Medical Licensing Examination (USMLE) based on standards established by the board;
(5) the Medical Council of Canada Qualifying Examination (MCCQE) in approved sequence;
(6) the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA);
(7) a written state examination of another state medical, osteopathic, or composite board prior to 1976, and current certification by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or another organization approved by the board; or
(8) combinations of the FLEX, National Board of Medical Examiners, and USMLE acceptable to the Composite Committee of the USMLE and approved by the board. These combinations may be accepted only if taken before 1999.

(1) For FLEX examinations taken before June 1, 1985, the following standards apply:

(a) An applicant for permanent licensure shall obtain, in one sitting, a FLEX weighted average score of at least seventy-five on the examination.

(b) FLEX examinations taken before June 1, 1985, were administered in three days and the days were referred to as Day 1, Day 2, and Day 3. In case of failure, the results of the first three takings of each day must be considered by the board, and the board may consider the results from a fourth taking of any day; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant's additional medical education or training, the applicant's score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of Day 1, Day 2, or Day 3, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

(2) For FLEX examinations taken after June 1, 1985, the following standards apply:

(a) An applicant for permanent licensure shall obtain a score of seventy-five or more on both Component I and Component II. An applicant shall pass both components within five years of the first taking of any component of this examination.

(b) FLEX examinations taken after June 1, 1985, were administered as Component I and Component II. In case of failure, the results of the first three takings of each component must be considered by the board. The board may consider the results from a fourth taking of any component; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant's additional medical education or training, the applicant's score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of Component I or Component II, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

(3) For the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination, or the Medical Council of Canada Qualifying Examination, the applicant shall pass all steps within ten years of passing the first taken step. The results of the first three takings of each step examination must be considered by the board. The board may consider the results from a fourth taking of any step; however, the applicant has the burden of presenting special and compelling circumstances why a result from a fourth taking should be considered. These circumstances may include, but are not limited to, the applicant's additional medical education or training, the applicant's score on the third taking, or other special or compelling circumstances. Under no circumstances may the board consider results received after the fourth taking of any step, except that a subsequent taking may be considered by the board for an applicant who currently holds a certification, recertification, or a certificate of added qualification by a specialty board recognized by the ABMS, AOA, or another organization approved by the board.

D. CURRENT COMPETENCY OR OTHER QUALIFICATIONS

In addition to meeting all other licensure requirements, an applicant shall pass the Special Purpose Examination (SPEX) or the Composite Osteopathic Variable-Purpose Examination (COMVEX), unless the applicant can document **within ten** years of the date of filing a completed application to the board one of the following:

(1) National Board of Medical Examiners examination;
(2) National Board of Osteopathic Medical Examiners examination;
(3) FLEX;
(4) USMLE;
(5) MCCQE;
(6) SPEX;
(7) COMVEX;

(8) COMLEX-USA;
(9) ECFMG;
(10) Certification, recertification, or a certificate of added qualification examination by a specialty board recognized by either the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or other organization approved by the board; or
(11**) <u>one hundred fifty hours of Category I continuing medical education in the three years preceding the date of the application</u>** by an applicant who is currently certified by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or other organization approved by the board, which certification is not time limited and does not require recertification by examination. Such Category I continuing medical education must be approved by the American Medical Association or American Osteopathic Association, or other national organization approved by the board, as appropriate. Seventy-five percent of these hours must be related to the applicant's area of specialty. This is the only exception to the ten year requirement of this subsection that does not require an examination or reexamination.

E. STATE AGENCY WAIVER

The additional examination required pursuant to subsection (D) must be waived if the applicant is to practice in a position within the South Carolina Department of Corrections, South Carolina Department of Health and Environmental Control, South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs. A license issued pursuant to this waiver is immediately invalid if the individual leaves that position or acts outside the scope of employment within the department. A change in agency may be approved upon presentation to the board of a copy of a contract in which the individual has been offered a position within the South Carolina Department of Corrections, the South Carolina Department of Health and Environmental Control, the South Carolina Department of Mental Health, or the South Carolina Department of Disabilities and Special Needs.

F. PRIMARY SOURCE VERIFICATION

An applicant shall file a completed application, with required supporting documentation, on forms provided by the department. Primary source verification of an applicant's identity, medical education, postgraduate training, examination history, disciplinary history, and other core information required for licensure in this State must be provided through an independent credentials verification organization approved by the board. Contact the Federation Credentials Verification Services (FCVS) at 400 Fuller Wiser Rd Suite 300, Euless TX, 76039, telephone (888) 275-3287 or e-mail fcvs@fsmb.org to request your Physician Information Profile.

G. CRIMINAL BACKGROUND CHECK (CBC)

Effective May 1, 2008, an applicant for an initial license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 40-47-36 of the Medical Practice Act. This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). (See Criminal Background check information)

H. TEMPORARY LICENSE

A temporary license, under certain circumstances, may be issued to applicants who meet all requirements for a permanent license and have filed a completed application. However, a "Yes" response to questions on the application may require an appearance before the full board before a temporary license can be issued. Temporary licenses expire at the end of each quarter.

I. INTERVIEW REQUIREMENTS

A personal interview with an individual Board member and/or the full Board is required before a permanent license can be issued. When your application is complete, you will be sent information about the personal interview along with setting up the interview with a member of the board or the full board.

J. LETTERS OF RECOMMENDATIONS

List the names and address on the application of three physicians willing to write letters of recommendations to support your application to the Board. You must request that each physician write directly to the Board on letterhead indicating that you are known to them, in what capacity and how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina.

K. LICENSE VERIFICATION

Licensure verification is required from each state board by which you are now or have ever been licensed to practice medicine. This verification should be sent directly to the South Board of Medical Examiners.

L. INSTRUCTIONS & INFORMATION ON COMPLETING THE APPLICATION

1. **Fee –** a non-refundable application fee of $580.00 is required with your application. Application will not be processed without the required $580.00 application fee. Make check payable to **LLR-Board of Medical Examiners. No cash, credit or debit cards are accepted.**

2. **Federation Credentials Verification Service (FCVS) - Required with permanent license application.** Request the FCVS from the Federation of State Medical Boards of the U.S. at 400 Fuller Wiser Rd Suite 300, Euless, TX 76039 or website www.fsmb.org; e-mail fcvs@fsmb.org; telephone (888) 275-3287.

3. **Special Purpose Examination Information** - **SPEX and COMVEX** information - A passing score on the SPEX or COMVEX examination is seventy-five (75) or better. For SPEX applications and additional information, contact the Federation of State Medical Boards of the U.S. Inc., P.O. Box 619850, Dallas, Texas 75261-9850; telephone (817) 868-4025; website: www.fsmb.org; e-mail address: spex@fsmb.org. COMVEX information: contact this board. This requirement is in addition to all other requirements for licensure.

4. **Verification of Licensure** – A verification form is enclosed and may be duplicated as needed. This board must receive a verification of licensure directly from the state board of each state in which you are *now or have ever been licensed* to practice medicine.

5. **Malpractice Form** – If applicable, complete and return the enclosed malpractice form with the requested information to the board if you have ever been named in a malpractice suit or settlement.

6. **Letters of Recommendations** – You must request that each physician write directly to the Board on letterhead indicating that you are known to them, in what capacity and how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina.

7. **Criminal Background Check (CBC) -** An applicant for an initial license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 40-47-36 of the Medical Practice Act. This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI).

8. **American Medical/Osteopathic Association Physician Profile** – An AMA or AOA physician profile must be received by the board. Please visit the AMA online at http://www.ama-assn.org/amaprofiles or the AOA online at www.aoa-net.org to request a profile be sent to the LLR-Board of Medical Examiners. You do not need to be a member to have the physician profile sent to the board.

9. **Controlled Substance Registration -** Applications for both federal and state registration are available from the Narcotic and Drug Control Division, Dept. of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201, (803) 896-0634. Applicants who possess permanent, temporary or limited licenses may apply for a controlled substance registration.

10. A licensee shall notify the board in writing within fifteen (15) business days of any change of residential address, office address, or office telephone number. Please mail or fax change of address information to the board or logon to www.llr.state.sc.us/pol/medical and report your change of address information to the board.

11. Application and fee will be kept on file for twelve (12) months; thereafter, a new application and fee are required. Application will be processed within 15 business days of the received date and you will be notified of any deficiencies in your file.

12. It is a violation of state law if a physician practices medicine before being issued a license. Violators are subject to fines and possible criminal prosecution.

13. Your application will not be considered completed or a temporary license issued until all of the required documents have been received in the board office.

14. The board must not issue a permanent license to a licensed physician of another state of the United States:
(1) whose license is currently revoked, suspended, restricted in any way, or on probationary status in that state; or
(2) who currently has disciplinary action pending in any state.

15. Please visit the Board's website at www.llr.state.sc.us/pol/medical to review the South Carolina Medical Practice Act.

16. Documented evidence of compliance with applicable continued competency is required for renewal of a permanent license. (See 40-47-40 of the Medical Practice Act)

17. A licensee shall notify the board within thirty (30) days of any adverse disciplinary action by another United States or foreign licensing jurisdiction, a peer review group, a health care institution, a professional or medical society or association, a governmental agency, a law enforcement agency, including arrest, or a court, including indictment. Confidential information received from a licensee or other sources must continue to be maintained as confidential, except to the extent necessary for the proper disposition of the matter. Please see the Medical Practice Act where notification is not required. (See 40-47-41D)

18. Allow 15 business days for processing before contacting the board regarding the status of your application. **You may check the status of your application online by visiting the Board's website at www.llr.state.sc.us/pol/medical.**

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Criminal Background Check (CBC)

Effective May 1, 2008, an applicant for a license to practice medicine in South Carolina shall be subject to a criminal history background check as defined in 40-47-36 of the Medical Practice Act.
This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI).
The cost of conducting a criminal history background check is $55.00. Make checks payable to Morphotrust USA.
To schedule an appointment online with Morphotrust USA, please visit www.identogo.com or call 1-866-254-2366 for assistance in scheduling your CBC.
South Carolina applicants will need to show one (1) form of identification - South Carolina State Issued Photo Drivers License.
For out of state applicants who do not hold a South Carolina State Issued Photo Drivers license, you will need to submit two (2) forms of identification from the list below:

State issued photo Drivers License
Social Security Card
Passport
Birth Certificate
Marriage License

If you are a non-resident of South Carolina and reside in an area where no Morphotrust USA fingerprinting centers are available, please follow the Non-Resident Card Scan Processing Procedures on the next page. Click here or visit webpage www.identogo.com to see if your state has Morphotrust USA fingerprinting centers.

Do not return fingerprint card or fingerprint processing fee to the Board.

ORI # SC920110Z

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Non-Resident Card Scan Processing Procedures

Applicants who reside in an area where no Morphotrust USA fingerprinting centers are available may use Morphotrust USA Card Scan Processing Program. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Converting a "hard card" into an electronic record enables an applicant to have their fingerprint record processed as quickly as if they had traveled to an electronic fingerprint processing location. The section below details the procedures for submitting fingerprints to the Card Scan Processing Unit.

South Carolina Licensing and Certification

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards.
- FBI applicant cards are available from the state agency requiring you to be fingerprinted (i.e. Department of Education, Insurance, Labor, Licensing, and Regulation, etc.). Please contact those licensing and certifying agencies directly to obtain fingerprint cards. *Due to agency specific information, Morphotrust USA does not provide fingerprint cards to applicants*.
- Applicants need to make sure the fingerprint cards are completely filled out. Required information includes: ORI number, full name, social security number, date of birth, home address, sex, height, weight, hair color, eye color, place of birth (state or country only), citizenship, and reason fingerprinted.
- The ORI number and Reason Fingerprinted that must be used for on the fingerprint card should be provided by the licensing or certifying agency. **ORI # SC920110Z**
- **Failure to completely fill out the information on the fingerprint card will result in the card being returned to the applicant, which will delay the licensing process**.
- The fully completed card, along with the appropriate fee (indicated in the application packet) should then be mailed to the following address:

Morphotrust USA
Attn: SC Card Scan Department
3051 Hollis Drive Suite 310
Springfield, IL 62704

Please include a daytime telephone number where the applicant can be reached in case there are questions about the fingerprint card.

- Please include the full name of the applicant on each check or money order.

- ***Do not send completed certification or licensing applications to Morphotrust USA***; these documents should be returned to the state agency that will be issuing the license.
- Applicants wishing to verify that a fingerprint card has been processed may call 866-254-2366 and speak with a customer service representative.

Morphotrust USA
3051 Hollis Drive, Springfield, IL 62704
Telephone 866-254-2366 Facsimile 800-272-2080 www.identogo.com

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APPLICATION TO PRACTICE MEDICINE

Complete all sections of this application by providing all of the requested information. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act.

PART I: Applicant Identifying Information

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**

5. **Title** ☐ M.D. ☐ D.O.	6. **Maiden Name**

7. **Mailing Address** (Street or PO Box, City, State, Zip)

8. **Home Address** (Street, City, State, Zip – not PO Box)	8a. **Home Congressional District**

8b. **Home Phone**	8c. **Home Fax**	8d. **Home Email**

9. **Business Name**	9a. **Business Address** (Street, City, State, Zip – not PO Box)

9b. **Business Phone**	9c. **Business Fax**	9d. **Business Email**

10. **Place of Birth** (List City & State or Country)	11. **Date of Birth MM/DD/YYYY**	12. **Gender**	13. **Race (For Statistical Purposes Only)**
		☐ Male ☐ Female	☐ African American/Black ☐ Hispanic/Spanish Origin ☐ American Indian ☐ Caucasian/White ☐ Asian/Oriental ☐ Other

PART II: Education Information

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		

Professional Education

List in chronological order from date of graduation to the present all professional education. Do not include continuing education coursework, apprenticeship, intern, residency, vocational training practical or clinical training.

INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

Revised 7/10/12

Are you a graduate from a medical school located outside of the United States or Canada?	**YES** ☐ **NO** ☐
Was your medical education / residency training interrupted other than for vacation periods? If yes, attach a written explanation.	**YES** ☐ **NO** ☐

PART III: Internship and Residency Training Information

Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action.

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No
		FROM (Month/Year)	TO (Month/Year)	

PART IV: Record of Examination(s)

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination (National Boards, FLEX, USMLE, etc.) attempt below. Attach additional sheets if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination(s)	State or Country	Date of Examination	Passed/Failed/Score (If score, enter score)

ECFMG (if applicable) Certificate Number_____ Permanent ECFMG Certificate: **YES** ☐ **NO** ☐

PART V: Record of Licensure

Complete the requested information below if you have ever been licensed to practice in any profession or occupation. You must identify the method by which you obtained your license(s) and include jurisdiction both within and outside the United States current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type (MD or DO)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date issued
State of original (initial) licensure:				
List other states of medical licensure:				

PART VI: Medical Specialty and South Carolina Location Information

1. Current medical specialty_____

2. South Carolina location:_____
Hospital/Clinic name

_____
Street Address City State Zip

3. Are you certified/recertified by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA)?_____ (If yes, list specialty board name below)

Board Name_____Year_____
Attach copies of American Specialty Board Certificates (ABMS or AOA)

4. Branch of military service_____date of service _____type of discharge_____
Attach a copy)

PART VII: Medical Practice Employment History

List all related employment (not training or residency) chronologically, most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable. Photocopy this page and attach if additional space is required.

1. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
2. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
3. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
4. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
5. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ Full-time ☐ Part-time	**Date of Employment** From: _____ To: _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**

PART VIII: Personal History Information

If you answer "**yes**" to any of the questions below (1-15), you must attach a full written explanation pertaining to that particular question.

1. Has your medical license ever been revoked, suspended, reprimanded, restricted or placed on probation by a Medical Licensing Board or other entity?	**YES** ☐ **NO** ☐
2. Have you ever had an application to practice medicine denied or refused by another medical licensing board or other entity?	**YES** ☐ **NO** ☐
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way?	**YES** ☐ **NO** ☐
4. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration?	**YES** ☐ **NO** ☐
5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action?	**YES** ☐ **NO** ☐
6. Are you currently under investigation or the subject of pending disciplinary action by any Medical Licensing Board, health care facility or other entity?	**YES** ☐ **NO** ☐
7. Is your medical license currently restricted in any way or have you ever been fined by any medical licensing board, or other entity?	**YES** ☐ **NO** ☐
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If yes, how many? _____ (Complete the attached Malpractice Information Claim Form, if applicable)	**YES** ☐ **NO** ☐
9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician?	**YES** ☐ **NO** ☐
10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	**YES** ☐ **NO** ☐
12. Have you ever discontinued the practice of medicine for any reason for one month or more?	**YES** ☐ **NO** ☐
13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity?	**YES** ☐ **NO** ☐
14. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)?	**YES** ☐ **NO** ☐
15. Have you ever been known by any other name or surname?	**YES** ☐ **NO** ☐

For Board Member use only

_____ _____

Applicant Signature (at time of interview) Date

_____ _____

Board Member Signature Date

PART X: Letters of Recommendation

Please supply below names and addresses of three physicians willing to write letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board (on letterhead)** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina. **Your application will not be considered complete until letters of reference from the three physicians identified below and all other materials necessary to support your application have been received.**

1. Name _____telephone ( ) _____

   Address_____City, State, Zip _____

2. Name _____telephone ( )_____

   Address_____City, State, Zip _____

3. Name _____telephone ( )_____

   Address_____City, State, Zip _____

PART XI: Handwriting

In your own handwriting, please write a brief statement (not more than fifty words) of the reason you wish to practice in South Carolina.

_____

_____

_____

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PART XI: Certifying Statement

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

_____
Signature of Applicant (Do not print)

_____
Printed Name of Applicant

_____
Date

Subscribed and sworn to before me this _____ day of

_____, _____.

_____
Notary Public Signature

My Commission Expires: _____

Attach professional photo here

(2x2)
Passport size

No copies

Do Not Staple

Did you remember to:

- ☐ Complete the application, attach photo & have notarized
- ☐ Complete the Affidavit of Eligibility (Next 2 pages)
- ☐ Attach application fee made payable to LLR-Board of Medical Examiners
- ☐ Request Primary Source verification – FCVS
- ☐ Complete Criminal Background process
- ☐ Send Licensure Verification Form to all states of licensure-current or inactive, if applicable
- ☐ Request AMA or AOA physician Profile
- ☐ Request three (3) letters of recommendations be sent directly to Board
- ☐ Complete Malpractice Claim Information Form, if applicable

For Office Use Only

Date Received: _____

Paid by: ☐Check ☐Money Order

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this Affidavit of Eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check the acceptable secure and verifiable document(s) you hold. A copy of the verifiable document(s) must be attached to the Affidavit of Eligibility.

☐ A valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card. Number _____; Date of Expiration: _____

☐ A valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit. State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where the secure and verifiable document(s) was issued.

_____

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____
(Include a copy of the card with the Affidavit)

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

_____ _____
Signature Date

_____
Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

06/28/12 Affidavit of Eligibility
10/05/12 Revised

South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

_____

Physician name Office telephone no.

_____

Address City State Zip

MALPRACTICE COMPLAINT: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Patient's Name: _____

Age: _____ Sex: _____

Date/place of occurrence:_____

Indicate your position in case, i.e., resident, primary physician, etc.: _____

_____

_____

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital
List names of other defendant-doctors and/or hospitals:

_____

_____

DISPOSITION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed ( )Dropped
If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ Total amt. paid (if any): _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: _____ Signature: _____

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VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed to practice medicine. You may want to contact each state to see if a fee is required.

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature _____

Name _____

Address _____

_____

City State Zip

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ( ) National Board ( ) FLEX Exam ( ) USMLE

( ) State Board Exam ( ) Other_____

License is current_____ If no, why not? _____

Has license been suspended, revoked, or restricted?_____ If yes, why? _____

Comments, if any_____

_____

Date: _____ Signature: _____

Board Seal Title: _____

Board: _____